LEGISLATIVE AUDIT DIVISION

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SCEG
MAY 15, 2012
EXHIBIT 15

MEMORANDUM

TO: Tori Hunthausen, Legislative Auditor
FROM: Diedra Murray Performance Auditor
Megan Coy, Performance Auditor
DATE: May 14, 2012
RE: Medicaid mental health utilization review contracting (#12P-09), Legislative request

Introduction

We received a request from the Select Committee on Efficiency in Government (SCEG), a legislative interim committee, for a performance audit of the Department of Public Health and Human Services' (department) contracts with Magellan Medicaid Administration, Inc. (Magellan) for utilization review (UR) of Medicaid mental health services. Magellan has two contracts with the department—one with the Children's Mental Health Services Bureau (CMHSB) worth $1.7 million and one with the Addictive and Mental Disorders Division (AMDD) worth approximately $200,000.

Committee Request

In its request, the SCEG provided a list of questions related to concerns raised during its work regarding improving efficiency of the state's Medicaid program related to the department's contracts with Magellan. These questions related to:

- The value of the contract
- The number of utilization reviews conducted, by fiscal year
- The appeal process
- Contract invoicing and reimbursement
- The department's monitoring of contractor performance

Based on the committee's request, we conducted an assessment to identify whether a performance audit is warranted at this time. Based on the nature of the SCEG questions, we looked specifically at the contract for utilization review of mental health services for youth with CMHSB; we did not conduct any work related to the contract with AMDD.

Although potential risk areas were identified, the department is currently in the process of securing a new contract; therefore, we believe a performance audit would be premature at this time. Discussions with department staff and review of the Request for Proposal (RFP) indicate the new contract may reduce or address the potential risk areas we identified during audit assessment work. To ensure concerns are addressed, we will propose an audit be conducted in the upcoming fiscal year and in the meantime, we will continue to monitor ongoing program changes. This memorandum provides details on questions raised by SCEG and the risk areas we identified.

Background

The requirement for utilization review became statutory in 1972 for Medicaid and Medicare programs. The federal government, through the Centers for Medicare and Medicaid Services, requires all agencies, which serve a Medicaid population and receive Medicaid funds to have a utilization review program in place to monitor beneficiary need for services before payment for the intended service is authorized.

Contract History

The contract for UR was first secured through a RFP process in 2005 and First Health Services of Montana, Inc. (First Health) was the successful offeror. Services provided included clinical review services for prior and continued stay authorizations of some mental health services for youth. In addition, First Health was required to conduct retrospective reviews of mental health services as requested, perform annual onsite inspection of care reviews of residential treatment providers, and maintain an adequate number of regional care coordinators across the state. Care coordinators are qualified mental health professionals and are responsible for participating in and providing clinical consultation to local providers regarding the treatment of children eligible for Medicaid or the Children's Mental Health Services Plan (CMHSP).

Since the execution of the original contract, it has been amended nine times. In general, most amendments extended the term of the contract, along with some changes to the types of services required under the contract. Amendment 5 changed the billing format of the contract so that, beginning with fiscal year 2010, monthly invoices are on a flat-fee basis. This is discussed further in this memorandum. Amendment 6, which occurred in June 2010, addressed a request made by First Health that the department consents to the transfer of the contract to Magellan because Magellan had acquired First Health. Through this amendment, Magellan fully assumed the obligations of First Health. The ninth amendment extended the contract until June 30, 2012.

Current Contract Status

Since the contract will expire on June 30, 2012, the department initiated an RFP process to secure a new contract. According to department staff, while the value of the contract will remain consistent, there will be some differences in the services provided under the contract. First, an additional regional care coordinator is required to increase availability of those services. Secondly, data and management information will be more readily available to the department.

Currently, the department is reviewing the lone proposal, submitted by Magellan. It is anticipated that the contract will be awarded in May 2012 and will take effect October 1, 2012. In the meantime, the department has entered into an exigency contract with Magellan. This contract is effective July 1, 2012 through September 30, 2012.

Contract Value

Since the first year of the contract the monthly value of the contract has increased by over 66 percent. The original contract was valued at a little more than $1.02 million for fiscal year 2006, with an average monthly value of $85,356. The following table provides a summary of the change in contract value over the course of the contract.

Table 1

Changes in Contract Value Fiscal Year 2006 to Present				
Contract Version	**Fiscal Year**	**Value**	**Price Per Month**	**Increase Over Previous Fiscal Year**
Original Contract	2006	$1,024,268	$85,356	N/A
Amendment 1	2007	$1,024,268	$85,356	0%
Amendment 3	2008	$1,575,789	$131,316	54%
Amendment 4	2009	$1,637,853	$136,488	4%
Amendment 5	2010	$1,706,354	$142,196	4%
Amendment 8	2011	$1,706,354	$142,196	0%
Amendment 9	2012	$1,706,354	$142,196	0%
Exigency Contract	2013	$142,196 per month (total $426,588)	$142,196	0%

Source: Compiled by the Legislative Audit Division from contract documents.

Services Provided by Magellan

Magellan currently provides four basic services to the department: regional care coordinator services, prior authorization reviews, continued stay reviews, and retrospective reviews. These are discussed below.

Regional Care Coordinator Services

The contract includes the services of five regional care coordinators spread throughout the state. The primary role of a care coordinator is to support comprehensive treatment planning through communication and coordination with providers and other stakeholders. Since care coordinators have first-hand knowledge of community resources, the contractor's clinical reviewers, discussed below, rely on the care coordinators to provide them with additional information about the availability of services in a particular community. Care coordinators may also provide clinical reviewers with information about specific youth. Both types of information may impact a clinical reviewer's determination about whether the medical necessity criteria are met for a particular youth.

Prior Authorization/Continued Stay Review Process

Once a community mental health provider has determined a specific treatment is appropriate for a youth qualifying for Medicaid, it may be necessary for the provider to request a prior authorization, depending on the service. In addition some services require authorization for continued stays. The table below lists the services which require review and the type of review required.

Table 2

Children's Mental Health Services Requiring Utilization Review			
Service	**Prior Authorization**	**Continued Stay Review**	**Certificate of Need Required**
Acute Hospital Inpatient (psychiatric admission)	X		X
Psychiatric Residential Treatment Facility (PRTF)	X	X	X
PRTF Home and Community-Based Services Waiver	X	X	X
Partial Hospitalization	X	X	X
Therapeutic Group Home	X	X	X
Therapeutic Family Care and Therapeutic Foster Care	X	X	X
Therapeutic Home Visits	X	Limit of 14 days per FY	
Outpatient Services (in excess of 24 sessions in state fiscal year)	X	X	
Case Management			
Community Based Psychiatric Rehabilitation Services (CBPRS)	X	X	

Source: Compiled by the Legislative Audit Division from department records.

All prior authorization and continued stay reviews must be submitted within specific timeframes. In addition, the request must contain clinical information about the client and a certificate of need (CON). The CON is based on the federal requirement for documentation of the need for inpatient hospitalization for Medicaid beneficiaries under age 21. Montana expanded on the federal requirement and requires a CON for other levels of care as well. A licensed mental health professional and a physician or psychiatrist must sign the CON.

Clinical reviewers employed by Magellan receive review requests, apply department-developed clinical guidelines, and determine if the request meets the criteria for medical necessity. Per the contract, all review staff are either licensed clinical social workers or registered nurses with specialized psychiatric training and must have five or more years of psychiatric experience as a licensed mental health professional. The review must be completed within a specific timeframe and additional information may be requested. If the community reviewer fails to provide the requested information, a technical denial may be issued.

If the medical necessity criteria are met, the reviewer authorizes the services. The clinical review staff can authorize care, but only board-certified psychiatrists have the authority to deny requests. If the medical necessity criteria are not met, the case is deferred to a board-certified psychiatrist for review and determination. As required by the contract, Magellan employs psychiatrists who handle denials and maintains a Montana-based panel of board-certified psychiatrists to review denials if they are appealed. Notification of the final decision is sent to the relevant parties. The figure below depicts the results of initial reviews for the period noted.

Figure 1

Source: Compiled by the Legislative Audit Division from department records.

Retrospective Reviews

All mental health services listed in Table 2 are eligible for retrospective review. The contractor may perform a retrospective clinical record review for two purposes:

- As requested by the department on a random sample basis.
- As requested by a community provider to establish the medical necessity for payment when the youth has become Medicaid eligible retroactively, or the provider was not enrolled in Montana Medicaid prior to the youth's admission.

A retroactive review may be conducted on-site or as a desk review. In both instances, the community provider is notified by letter and given a list of the records to be reviewed. Retrospective reviews may be used to verify any of the following:

- There is sufficient evidence of medical necessity for payment.
- The patient is engaged in active and appropriate treatment consistent with standards of practice for the diagnosis, age, and circumstances of the individual.
- The criteria for having a serious emotional disturbance have been met.

The review process is similar to that of a prior authorization/continued stay review.

Appeal Process

If a request is denied, it may be appealed by either the community provider or the client's legal custodian. If the initial denial is overturned at any step in the appeal process, the requested service is retroactively approved and Medicaid will pay for the service. However, the cost of the time and effort expended by the community provider during the appeal is not reimbursable. The appeals process has three parts:

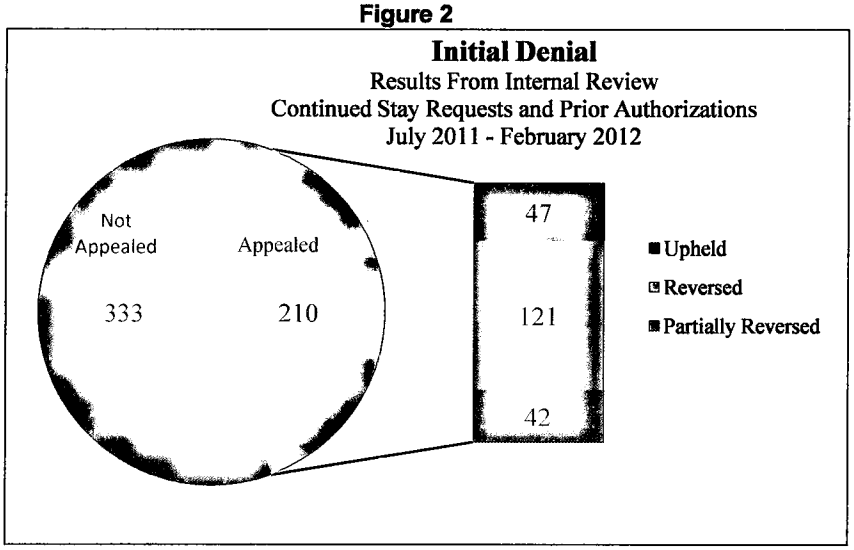
- An internal review of the clinical decision conducted by a psychiatrist employed by the contractor.
- An administrative review conducted by department staff.
- A fair hearing conducted by the department.

Internal Review

If Magellan denies the initial request, the first step in the appeal process is an internal reconsideration. The purpose of the reconsideration is to allow a second clinical opinion and any additional information not available during the initial review. The request is reviewed by a psychiatrist licensed to practice in

Montana who was not involved in the original determination but is employed by Magellan. The request for reconsideration must specify the type of review desired—either a desk review or a peer-to-peer review. During a desk review, the reviewing psychiatrist evaluates the documentation submitted with the request. During a peer-to-peer review, the documentation is reviewed, but the reviewer also speaks with the community provider to discuss pertinent information. The figure below shows the results from the internal review for the period noted.

Figure 2



Source: Compiled by the Legislative Audit Division from department records.

Administrative Review

If Magellan denies the request during either review, an administrative review may be requested. This review is conducted by department staff who are licensed mental health providers. Because staff members are not psychiatrists, this review is a process review to ensure the contractor followed the process developed by the department. According to department staff, there is minimal chance a denial will be overturned because they give considerable weight to the fact that two psychiatrists have already reviewed and denied the request.

Fair Hearing

If the community provider or legal custodian is not satisfied with the department's determination following the administrative review, they have a specific timeframe to request a fair hearing. The department refers the request to its Office of Fair Hearings, which follows hearing procedures outlined in administrative rule. Magellan may participate in the fair hearing process to provide testimony, along with copies of documentation and correspondence related to the determination under appeal, as necessary.

Contract Invoices and Payments

We reviewed invoices submitted by Magellan to the department for July 2008 through February 2012. In fiscal year 2009, Magellan billed the department based on the amount of reviews conducted each month. In fiscal year 2010, an amendment was made to the contract. The amendment changed the billing to a flat-fee regardless of the number of reviews conducted by Magellan each month. The flat-fee was equal to 1/12 of the contract amount.

Based on our review of Magellan's invoices and SABHRS data, we were able to verify the contractor submitted monthly invoices to the department and the department paid Magellan for services provided. In fiscal year 2009, the invoice and corresponding payment amounts were calculated using the actual

number of reviews and a determined rate for each type of review. From July 2009 to February 2012, monthly invoices and payments were equal to 1/12 the contract amount. The department's payments for each fiscal year matched the overall value of the contract for the fiscal year.

Invoice Requirements

The original contract required Magellan to submit monthly invoices to the department. According to the contract, Magellan was required to split the cost of services between clinical review and care coordinator-related expenditures. Additionally, Magellan was required to distinguish between services provided in support of Medicaid recipients 17 years of age or younger and those furnished in support of CMHSP recipients 18 years of age or younger. According to department staff, the purpose of tracking the age of recipients was to track Medicaid recipients transferring from the youth mental health system to the adult system.

In fiscal years 2009, 2010, 2011, and 2012, we noted the contractor distinguished between clinical review and care coordinator services. However, in fiscal year 2010, the contract was amended and no longer required the contractor to distinguish between services provided in support of Medicaid recipients 17 years of age or younger and those furnished in support of CMHSP recipients 18 years of age or younger. According to the department, the CMHSB no longer needed this information because the contractor was providing AMDD with the information. The following table shows the amount of clinical review and care coordinator expenditures by fiscal year.

Table 3

Clinical Review and Regional Care Coordinator Expenditures
Fiscal Years 2009-2012

Fiscal Year	Clinical Review	Regional Care Coordinator Services
2009	$ 1,080,022	$ 557,831
2010*	$ 1,169,978	$ 536,376
2011*	$ 1,169,978	$ 536,376
2012*	$ 1,169,978	$ 536,376

* Flat-Fee Fiscal Years

Source: Compiled by the Legislative Audit Division from department records.

Number of Reviews

The number of projected reviews was included in the contract each time it was extended. The number of actual reviews conducted each month is then included on the monthly invoices Magellan submits to the department.

In fiscal year 2009, Magellan was paid based on the number of reviews and the established rate for each service. However, the total reimbursement could not exceed $1,637,853. In fiscal years 2010, 2011, and 2012, Magellan was paid a flat fee for services. Beginning in fiscal year 2010, contract language states if the actual number of clinical reviews is projected to vary from the number of clinical reviews estimated in the contract by 15 percent or more, over a period of at least three months, the parties agree to open the contract and renegotiate pricing. However, contract language does not specify whether this requirement is by service type (e.g. therapeutic youth family care, residential treatment, etc.) or total number of clinical reviews.

During our review we found, in fiscal years 2010 and 2011, for specific review types, the actual reviews exceeded the number of estimated reviews by 15 percent for at least three months. However, as seen in

the Table 4, the total amount of actual clinical reviews did not exceed the total estimated number of clinical reviews by 15 percent. While contract language is unclear, the department stated they have not opened the contract or renegotiated the contract due to the number of clinical reviews conducted because it is their belief the contract language, though not specific, refers to the total number of reviews conducted. The following table shows the total number of reviews projected in the contract and the actual amount of reviews conducted by fiscal year.

Table 4

Projected and Actual Number of Clinical Reviews Fiscal Years 2010-2012		
Fiscal Year	**Projected Clinical Reviews**	**Actual Clinical Reviews**
2010	14,372	14,851
2011	14,372	12,295
2012*	9,371	5,566*
*Fiscal Year 2012 numbers represent actual through March 2012.		
Source: Compiled by the Legislative Audit Division from department records.		

We also conducted an analysis to compare the number of clinical reviews conducted compared to clinical review expenditures for each fiscal year. Table 5 shows the results of this analysis.

Table 5

Dollars Per Clinical Review Fiscal Years 2009-2011			
Fiscal Year	**Number of Clinical Reviews**	**Clinical Review Expenditures**	**$ Per Clinical Review**
2009	13,273	$1,080,022	$ 81.37
2010*	14,851	$1,169,978	$ 78.78
2011*	12,295	$1,169,978	$ 95.16
*Flat-Fee Fiscal Years			
Source: Compiled by the Legislative Audit Division from department records.			

As can be seen in the table, on a per review basis, the state paid Magellan $78.78 per clinical review in fiscal year 2010 and $95.16 in fiscal year 2011. However, we did not see a significant difference in the amount paid per review based on the contract moving to a flat-fee basis.

Department Monitoring of the Contract

According to department staff, they are satisfied with Magellan's performance under the contract. They believe Magellan has done what the department has asked of them, but note some community providers may be unhappy due to the subjectivity of medical necessity.

We reviewed the department's monitoring of its contract for quality assurance and identified three areas of potential weakness:

- The department has an informal process for handling complaints about the Magellan's performance.
- The department does not conduct random reviews of determinations for quality assurance purposes.
- The department lacks management information about determinations conducted.